(X3) DATE SURVEY

Kansas Department on Aging

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
		N087054	B. WING		04/28/2016
	ROVIDER OR SUPPLIER	9191 E 21	DDRESS, CITY, STA ST ST N . KS 67206	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
S 000	INITIAL COMMENTS		S 000		
	Surveyor: 08970 The following citations Licensure resurvey at Residential Health Ca Kansas on 4/26/16, 4/ Complaint #99223 als	the above named are Facility in Wichita, /27/16, and 4/28/16.			
	26-41-204 (d) Health	Care Services	S3165		
SS=E	contain a description to be provided and the	ervice agreement shall of the health care services e name of the licensed the implementation and n.			
	This REQUIREMENT by: Surveyor: 08970 KAR 26-41-204(d)	is not met as evidenced			
	observations, and rev three sampled (#189 a failed to ensure the ne	ents. Based on interviews, iews of records, for two of and #187), the Operator egotiated service agreement scription of the health care			
	Findings included:				
	facility 4/15/16 with di Depression, Behavior disorder with behavior disorder, Hepatitis C,	s, Major neuron-cognitive ral disturbances, Bipolar and Cirrhosis of liver.			
	The 4/14/16 FCS (fun assessed #189 in nee	ctional capacity screen) ed of medication and			

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

NAME OF PROVIDER OR SUPPLIER BROOKDALE EAST WICHITA STREET ADDRESS, CITY, STATE, ZIP CODE 9191 E 21ST ST N WICHITA, KS 67206 CM4/ID PREFIX TAG COMMANY STATEMENT OF PERCICINES BY PALL FROM THE SEQUENCE OF MIGHT REPRESENCE BY PALL FROM THE SEQUENCE OF THE SEQUENCE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
PRECIX TAG Continued From page 1 Salaman Salaman			N087054	B. WING		04/2	8/2016
Majib PROVIDER'S PLAN OF CORRECTION STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CONNECTION PREFIX REDUATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DISTRICT OR STATEMENT PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DISTRICT OR STATEMENT PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DISTRICT OR STATEMENT PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DISTRICT OR STATEMENT PROVIDER STAT	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH ORDERTIVE ACTION SOULD BE COMPAIRED METERS) CONTINUED FROM PROPRIATE DEFICIENCY) S3165	BROOKD	ALE EAST WICHITA					
treatment management. The 4/14/16 NSA (negotiated service agreement) documented #189 to receive medication and treatment management by facility and Home Heatilh to provide insulin injections. The NSA documented "Large" for meal portion but lacked the physician ordered diet of 60 gram carbohydrate Diabetic diet. (This diet ordered at time of discharge from hospital/admit to facility on 4/15/16). By review of April 2016 MAR, indicated facility staff administered insulin. On 4/27/16 at 1:27pm, Health and Wellness Director #C confirmed the NSA lacked a correct description of the health care services to be provided in regard to insulin administration and therapeutic diet ordered. The Operator failed to ensure the NSA for #189 contained a description of the health care services to be provided. - Review of record revealed #187 admitted to facility 12/29/15 with diagnoses of Dementia, Hypothyroidism, Asthma, Alzheimer's, Chronic kidney disease, Glaucoma, and Dysphagia. The current FCS of 02/16/16 assessed #187 unable to perform bathing, dressing, toileting, transfers, mobility, eating, medication and treatment management; with incontinence, cognitive impairment, impaired communication,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETE
The current NSA of 02/17/16 documented staff to manage medications and treatments, and to provide meals with therapeutic diet. The NSA	S3165	treatment management The 4/14/16 NSA (new documented #189 to treatment management Health to provide insume the NSA documented but lacked the physicic carbohydrate Diabetic time of discharge from 4/15/16). By review of April 2013 staff administered insumer of the NSA documented insumer of the NSA documented insumer of the NSA of Omanage medications. The Current NSA of Omanage medications.	gotiated service agreement) receive medication and ent by facility and Home ulin injections. d "Large" for meal portion ian ordered diet of 60 gram de diet. (This diet ordered at in hospital/admit to facility on 16 MAR, indicated facility ulin. 17 Health and Wellness de the NSA lacked a correct alth care services to be insulin administration and ded. 18 ensure the NSA for #189 on of the health care ded. 19 evealed #187 admitted to diagnoses of Dementia, ma, Alzheimer's, Chronic coma, and Dysphagia. 19 16/16 assessed #187 ching, dressing, toileting, thing, medication and ent; with incontinence, impaired communication, liness. 19 2/17/16 documented staff to and treatments, and to	S3165			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		N087054	B. WING		04/2	28/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	<u>, </u>	<u></u>
		9191 E 21		· - , · · · · · · · · · · · · · · · · · ·		
BROOKD	ALE EAST WICHITA	WICHITA	KS 67206			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S3165	Continued From page	2	S3165			
	lacked the physician of	ordered Pureed diet.				
		27/16 at 12:15pm, #187 and assisted with eating by				
		n Health and Wellness dent Care Coordinator #E ot accurate for the health				
	The Operator failed to contained a description services to be provided					
S3200 SS=E	26-41-205 (d) (1-2) Fa Medications	acility Administration of	S3200			
	administration of a resadministrator or operamedications and biologous that resident in according provider's written or of practice, and each recommendations. The shall ensure that all of (1) Only licensed numbers.	lity is responsible for the sident 's medications, the ator shall ensure that all egicals are administered to dance with a medical care der, professional standards manufacturer 's he administrator or operator of the following are met: sees and medication aides manage medications for responsibility.				
	This REQUIREMENT	is not met as evidenced				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		N087054	B. WING		04/28/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
		9191 E 2	1ST ST N		
BROOKD	ALE EAST WICHITA	WICHITA	, KS 67206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
\$3200	three Residents. The Residents as receivin management. Based review for three of thr and #185), the Opera medications and biolog Residents in accordate provider's written order professional standard. Findings included: Review of record refacility 4/15/16 with didication, Behavior disorder with behavior disorder, Hepatitis C, The 4/14/16 FCS (fundassessed #189 in new treatment manageme) The 4/14/16 NSA (new documented #189 to treatment manageme) Initial review of the more revealed no signed more in chart to support the (medication administrated). On 4/27/16 Health an #C provided orders signospital discharge/factions.	34 the sample included facility identified all g medication and treatment on interview and record ee sampled (#189, #187, tor failed to ensure all ogicals administered to example to example to example to example to example to exist a medical care exist and in accordance with sof practice. Vealed #189 admitted to agnoses of Diabetes, example to examp	\$3200		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 9191 E 21ST ST N WICHITA, KS 67206 PRETX TAG CONTINUED FOR ISSUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY NUST THE PRECIDED BY INIL.) REGULATORY OR ISS. DENTIFYING INFORMATION) S3200 Continued From page 4 orders with April 2016 MAR revealed: 4/15/16 - discharge order for Miralax 17 grams oral every day, not included on the Resident's MAR for administration, and not clarified for discontinuing 4/17/16 - phone order - lbuprofen 200mg (milligrams) po (by mouth) every six hours PRN (as needed) fever, transcribed incorrectly onto MAR as "PRN pain/fever." On 4/27/16 at 1:45pm, HWD #C confirmed the Miralax order not included on MAR, not discontinued, and not addressed confirmed the Ibuprofen order transcribed incorrectly onto MAR from original order confirmed not completed according to standards of practice. The Operator failed to ensure all medications and biologicals administered to #189 in accordance with a medical care provider's written orders and in accordance with professional standards of practice. - Review of record revealed #187 admitted to facility 12/29/15 with diagnoses of Dementia, Hypothyroidism, Asthma, Alzheimer's, Chronic kidney disease, Glaucoma, and Dysphagia.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION REQULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE COMPLETE THAT IT ASSOCIATED AS A CONSTRUCTIVE ACTION SHOULD BE COMPLETE THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE COMPLETE DIATE CONSTRUCTIVE ACTION SHOULD BE COMPLETE DIATE CONSTRUCTIVE ACTION SHOULD BE COMPLETE THE APPROPRIATE DIATE CONSTRUCTIVE ACTION SHOULD BE COMPLETE DIATE CONSTRUCTIVE ACTION THE APPROPRIATE DIATE CONSTRUCTIVE ACTION T			N087054	B. WING		04/:	28/2016
SASON SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES DEACH DEFICIENCIES TAG	BROOKD	ALE EAST WICHITA					
orders with April 2016 MAR revealed: 4/15/16 - discharge order for Miralax 17 grams oral every day, not included on the Resident's MAR for administration, and not clarified for discontinuing 4/17/16 - phone order - Ibuprofen 200mg (milligrams) po (by mouth) every six hours PRN (as needed) fever; transcribed onto MAR as "PRN pain/fever." On 4/27/16 at 1:45pm, HWD #C confirmed the Miralax order not included on MAR, not discontinued, and not addressed confirmed the Ibuprofen order transcribed incorrectly onto MAR from original order confirmed not completed according to standards of practice. The Operator failed to ensure all medications and biologicals administered to #189 in accordance with a medical care provider's written orders and in accordance with professional standards of practice. - Review of record revealed #187 admitted to facility 12/29/15 with diagnoses of Dementia, Hypothyroidism, Asthma, Alzheimer's, Chronic	PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	HOULD BE	COMPLETE
The current FCS of 02/16/16 assessed #187 unable to perform medication and treatment management. The current NSA of 02/17/16 documented staff to manage medications and treatments. Comparison of most recent signed physician orders with April 2016 MAR (medication administration record) revealed:	\$3200	orders with April 2016 4/15/16 - discharge of oral every day, not in MAR for administration discontinuing 4/17/16 - phone orde (milligrams) po (by moreover) (as needed) fever; transparent of the milligrams) po (by moreover) (as needed) fever; transparent of the milligrams) po (by moreover) (by proposition or descontinued, and not libuprofen order transform original order according to standard or the Operator failed to biologicals administed with a medical care print of the milligrams of the milligrams of the milligrams of the current FCS of the current FCS of the current NSA of the current NSA of the current NSA of the current of milligrams of most orders with April 2016	order for Miralax 17 grams included on the Resident's ion, and not clarified for er - Ibuprofen 200mg iouth) every six hours PRN in anscribed onto MAR as in the seribed incorrectly onto MAR confirmed the seribed incorrectly onto MAR confirmed not completed dis of practice. To ensure all medications and irred to #189 in accordance provider's written orders and ion of essional standards of evealed #187 admitted to a diagnoses of Dementia, inma, Alzheimer's, Chronic incoma, and Dysphagia. To 2/16/16 assessed #187 edication and treatment in and treatment. To 2/17/16 documented staff to a rand treatments. The event signed physician is MAR (medication in the residuent in the signed physician is MAR (medication in the residuent in the signed physician is MAR (medication in the residuent in the res	\$3200			

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		N087054	B. WING		04/28/2016
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 04/20/2010
BROOKD	ALE EAST WICHITA	9191 E 21S WICHITA, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S3200	Continued From page	e 5	S3200		
	physician included: Pro Stat supplement of Prevalon Boots to bill offloading Calazime to buttocks Moisturizer to upper a (twice daily). Skin prep to bilateral dressing change daily wraps) in the morning These orders not transevidence of clarification located. On 4/27/16 at 1:14pm Director #C confirmed transcribed in accordant standards of practice. The Operator failed to biologicals administer with a medical care p	heels and apply padded and PRN (under ACE for wounds. Is scribed onto the MAR. No con to discontinue the orders of these orders not ance with acceptable			
	facility 9/27/13 with di	evealed #185 admitted to agnoses of Dementia, Left , Depression, Anxiety, pronic kidney disease.			
		1/14/15 assessed #185 in nd treatment management.			
	The 11/14/15 NSA do medication and treatm	cumented #185 to receive nent management.			
	Comparison of most r	ecent signed physician			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		N087054	B. WING	·····	04/28/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
BROOKD	ALE EAST WICHITA		1ST ST N ., KS 67206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETE
\$3200	Novolog Flex Pen 6 u added to the facility F By observation on 4/2 Novolog Flex pens in storage room refrigers 02/23/16. By interview on 4/27/7 Nurse #N stated not sin refrigerator, not add By review of MAR's for insulin administered to By interview on 4/27/7 Coordinator #E stated from the hospital returned by the conditional form on 02/23/16 or mon 02/24/16 the APRI registered nurse) made discontinued the insulance of 02/24/16 the APRI registered nurse) made discontinued the insulance of 02/24/16 the APRI registered nurse) made discontinued the insulance of 02/24/16 the APRI registered nurse) made discontinued the insulance of 02/24/16 the APRI registered nurse) made discontinued the insulance of 02/24/16 the APRI registered nurse) made discontinued the insulance of 02/23/16.	S MAR (medication or revealed: scharge order for Insuling inits three times daily, not ebruary MAR 27/16 at 11:00am, three the facility medication ator, delivered to facility 16 at 11:00am, Licensed sure why pens ordered and ministered and not returned. or February and March, no or #185. 16 at 5:15pm, Resident Care of I initially faxed the orders or to the pharmacy the y must have realized #185 in prior to hospital and did on the MAR or give it the norning of 02/24/16 then N (advanced practice de a visit to facility and lin due to lab (Hemoglobin I that's why not used eturn to pharmacy since Coordinator #E and Health or #C each acknowledged no or documentation in /23/16 to explain why insulin	S3200		
		red to #185 in accordance			

Kansas L	Department on Aging					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		N087054	B. WING		04/2	8/2016
					1 0-112	0,2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE EAST WICHITA	9191 E 21	ST ST N			
Ditto Oitib	ALL LIKE WIGHT	WICHITA	KS 67206			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
S3200	Continued From page	e 7	S3200			
		provider's written orders and rofessional standards of				
S3215 SS=D	26-41-205 (h) Medica	ation Storage	S3215			
	(h) Storage. Licensed	d nurses and medication				
	aides shall ensure that	at all medications and				
	_	ely and properly stored in				
	accordance with each					
		those of the pharmacy				
		eral and state laws and				
	regulations.	or madication aidea aball				
		or medication aides shall medications and biologicals				
		ity in a locked medication				
		dication cart. Licensed				
	nurses and medication					
		is managed by the facility in				
		mpartments within a locked				
		oinet, or medication cart.				
		and medication aides shall				
	have access to the st	tored medications and				
	biologicals.					
	(2) Each resident ma					
	self-administering me					
		e that is accessible only to				
	· ·	I nurses, and medication				
	aides.					
		self-administers medication				
	and is unable to prov					
		manufacturer or pharmacy				
	stored by the facility.	that the medication be				
		or medication aide shall not				
	` '	n beyond the manufacturer '				
		er 's recommended date of				
	expiration.	c. c recommended date of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		N087054	B. WING	·····	04/28/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	
BROOKD	ALE EAST WICHITA		1ST ST N ., KS 67206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
S3215	Continued From page	8	S3215		
	This REQUIREMENT by: Surveyor: 08970 KAR 26-41-205(h)	is not met as evidenced			
	three Residents. The Residents who used i the sample. Based or review of record, for c who used insulin, the	nsulin and one included in observation, interview, and one of one sampled (#189) licensed nurses and od to ensure insulin pens			
	medication storage ronurses and medication in the refrigerator of the refrigerator contained with unopened insuling refrigerator also contained three open and in use insuling pens in use easily albeit with the Resider medical care provider administration direction included the date the third pen did not included.	ained a plastic bag with a insulin pens inside. The ach contained a prescription of the name, the ordering of the delivery date, and ons. Two of the three pens pen first used/opened, the			
	Nurse #J, and Certifie	m, Resident Care censed Nurse #E, Licensed ed Medication Aide #I all ns in use and stored in the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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BROOKD	ALE EAST WICHITA	9191 E 21 WICHITA,	ST ST N KS 67206			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	E
S3215	manufacturer direction the refrigerator reveal store at room temperators. Review of in use pensiplastic baggie with the Novolog pension and on also contained three to pension shelf). On 4/27/16 at 11:00al confirmed the pension shelf). On 4/27/16 at 11:00al confirmed the pension about refriuse acknowledged on the unopened box temperature storage. Review of facility policinsulin Pen - 36" reversions must be stororiginal box until time. 2. Pens in use will be stored at room temper medication cart until to manufacturer.	f stickers on the pen ." In addition review of ns on insulin pen boxes in led specific directions to ature once opened/in use. s in refrigerator revealed ree pens for #189 - Two e Levemir pen. (Refrigerator boxes of unopened Lantus m, Licensed Nurse #N Il in use/open inside the ave had conflicting rigerating them or not after in the manufacturer directions es indicated room cy and procedure "Use an aled: ed and refrigerated in their of use e dated upon opening and rature (59F to 86F) in the he time specified by the and medication aides failed and medication aides failed and medication aides failed and medication aides failed	S3215			
S3248 SS=F	26-41-102 (d) Staff Q Records	ualifications Employee	S3248			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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BROOKD	ALE EAST WICHITA	9191 E 21 WICHITA	ST ST N KS 67206			
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S3248	records shall contain documentation: (1) Evidence of licens certification, or a certicompletion of a training employee performing specialized education (2) supporting docume background checks of staff, excluding any sea state agency, pursuamendments thereto; (3) supporting documents aide registry the have a finding of having exploited a resident in (4) supporting documents of have a finding of having exploited a resident in the supporting documents of have a finding education of have a finding education of the supporting documents of the supporting documen	tords and agency staff the following sure, registration, ficate of successful ing course for each a function that requires or training; entation for criminal if facility staff and contract taff licensed or registered by lant to K.S.A. 39-970 and entation from the Kansas at the individual does not ing abused, neglected, or in an adult care home; and entation that the individual ing of having abused, d any resident in an adult inurse aide registry in each ividual has been known to	S3248			
	This REQUIREMENT by: Surveyor: 08970 KAR 26-41-102(d)(2)	is not met as evidenced				
	The census equaled 34 the sample included 3 residents. The facility identified 71 employees hired since the last visit, with five of these reviewed. Based on interviews and reviews of records, for 5 of 5 Certified staff reviewed, (#A, #B, #C,#D, and #E), the Operator failed to ensure the employee record contained supporting					

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BROOKD	ALE EAST WICHITA		1ST ST N ., KS 67206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S3248	as required by the De Findings included: - Review of personne 1:30pm with Business revealed: #A - Certified Medicat 3/14/16 - no supportir background check #B - CMA - hired 02/2 documentation of crin #C - CMA - hired 01/2 documentation of crin #D - Certified Nurse A no supporting docume background check #E - CNA - hired 3/16 documentation of crin By interview on 4/26/- Office Manager #G premployee files that lar required criminal back Surveyor reviewed ar which lacked evidence criminal background of for these employees s listed above. The Operator failed to	minal background checks, partment. el records on 4/26/16 at a Office Manager #G cion Aide (CMA) - hired and documentation of criminal background check el 7/16 - no supporting anial background check el (CNA) - hired 4/08/16 - entation of criminal el 4/16 - no supporting anial background check el 6 at 1:30pm, Business arovided documentation from cked the Department arground checks #G and an online listing of employees en Department required checks requested by facility since recorded times of hire	S3248		
	records for #A, #B, #0 supporting documental background checks, a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPLI	(X3) DATE SURVEY COMPLETED	
		N087054	B. WING		04/2	8/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BROOKDALE EAST WICHITA 9191 E 21ST ST N WICHITA, KS 67206							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S3248	Continued From page Department.	2 12	S3248				